MOTION FILED

JUN 2 2000

(15)

No. 99-936

In The

Supreme Court of the United States

CRYSTAL M. FERGUSON, *et al.*,

Petitioners,

v.

THE CITY OF CHARLESTON, SOUTH CAROLINA, *et al.*,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF NEITHER PARTY

*Michael Ile
Anne Murphy
Leonard Nelson
Carolyn Quinn
American Medical Association
515 N. State Street
Chicago, Illinois 60610
Telephone: (312) 464-5000

Attorneys for Amicus Curiae
(**Counsel of Record*)

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

35 pp

MOTION OF AMERICAN MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

Pursuant to Sup. Ct. Rule 37.2(b), *Amicus Curiae* the American Medical Association (the "AMA") moves this Court for leave to file the accompanying brief.

As the nation's largest association of physicians, the AMA can offer this Court a unique perspective on the public health issues implicated by the instant appeal, including an analysis of applicable scientific research. The AMA further seeks to inform this Court of the AMA's internal policies and opinions relevant to this case. The AMA believes that the United States Court of Appeals for the Fourth Circuit errantly disposed of issues critical to this appeal, and the AMA wishes to address public health concerns that are relevant to the proper resolution of those issues.

The American Medical Association has been unable to secure the consent of either party to the filing of its brief.

Respecfully submitted,

*Michael Ile
Anne Murphy
Leonard Nelson
Carolyn Quinn
American Medical Association
515 N. State Street
Chicago, Illinois 60610
Telephone: (312) 464-5000

Attorneys for Amicus Curiae
(**Counsel of Record*)

TABLE OF CONTENTS

Page

Table of Contents i

Table of Authorities ii

Statement of Interest 1

Summary of Argument 2

ARGUMENT 4

I. Criminal Sanctions Are Not Effective in Halting Drug Abuse By Pregnant Women 6

II. The Charleston Policy Discouraged Prenatal and Postnatal Care by Undermining the Physician/Patient Relationship 10

A. Failure to Disclose Drug Use Can Delay Treatment for Harm Caused by Exposure .. 12

B. Even If Drug Use Is Not Discontinued, Prenatal Care Can Significantly Reduce the Risk of Harm to Infants 14

C. Positive Contact With Medical Providers Prenatally Can Contribute to Postnatal Infant Health and Development. Criminalization Detracts From Postnatal Development..... 18

Conclusion 22

APPENDIX .....App. 1

TABLE OF AUTHORITIES

Page

CASES

Chandler v. Miller, 520 U.S. 305 (1997) 4

Ferguson v. City of Charleston, 186 F.3d 469 (4th Cir. 1999) ..... *passim*

Linder v. United States, 268 U.S. 5 (1925) 8

National Treasury Employees Union v. Von Raab, 489 U.S. 656 (1989) 4

Robinson v. California, 370 U.S. 660 (1962) 8

OTHER AUTHORITIES

American Medical Ass'n, *Legal Interventions During Pregnancy*, 264 J.A.M.A. 2663 (1990) 8, 9, 16

American Medical Ass'n, *Policy Compendium* E-5.05 at 98 (1999) 11

American Medical Ass'n, *Policy Compendium* H-95.976 at 229 (1999) 8

American Medical Ass'n, *Policy Compendium* H-95.983 at 231 (1999) 10

American Medical Ass'n, *Policy Compendium* H-420.962 at 610 (1999) 9

American Medical Ass'n, *Policy Compendium* H-420.969 at 612 (1999) 9

American Medical Ass'n, *Policy Compendium* H-420.970 at 612 (1999) 9

American Medical Ass'n, *Policy Compendium* H-515.969 at 696 (1999) 11

TABLE OF AUTHORITIES – Continued

Page

American Medical Ass'n, *Policy Compendium* H-515.982 at 699-70 (1999) 11

American Medical Ass'n, *Policy Compendium* H-515.992 at 701 (1999) 11

American Medical Ass'n, *Policy Compendium* H-515.999 at 702 (1999) 11

American Medical Ass'n, *Perinatal Addiction: Issues in Care and Prevention*, Report of the Council on Scientific Affairs (Rpt. G-A92) (1992) ..... *passim*

American Medical Ass'n, *Proceedings of the House of Delegates: 43rd Interim Meeting*, Board of Trustees Report Y 95 (Dec. 3-6, 1989) 15, 16, 17

American Medical Ass'n, *The Reduction of Medical and Public Health Consequences of Drug Abuse*, Report of the Council on Scientific Affairs, Rpt. 8-A-97 (1997) 13

American Medical Ass'n, *Proceedings of the House of Delegates: 137th Annual Meeting*, Board of Trustees Report NN 236 (June 26-30, 1988) .. 7, 15, 16

American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 176 (4th ed. rev. 1994) 7, 8

Chasnoff, *Drug Use in Pregnancy: Parameters of Risk*, 35 The Pediatric Clinics of No. Am. J., 1403 (1988) 12, 15, 20

Cherukuri, Minkoff, Feldman, Parekh & Glass, *A Cohort Study of Alkaloidal Cocaine ("Crack") in Pregnancy*, 72 Obstetrics and Gynecology 147 (1988) 15

TABLE OF AUTHORITIES – Continued

Page

Finnegan, Connaughton, Emich & Wieland, *Comprehensive Care of The Pregnant Addict and Its Effect on Maternal and Infant Outcome*, 1 Contemp. Drug Problems 795 (1972) 14, 18

Frank, Zuckerman, et al., *Cocaine Use During Pregnancy, Prevalence and Correlates* 82 Pediatrics 888 (1988) 15, 16

Gain & Clabber, *Abstinence Symptomology and Psychiatric Diagnosis in Cocaine Abusers: Clinical Observations*, 43 Arch. Gen. Psychiatry 107 (1986) 13

Garrison, *Why Terminate Parental Rights?*, 35 Stan. L. Rev. 423 (1983) 21

Getting Straight, Overcoming Treatment Barriers for Addicted Women And Their Children: Hearing Before the Select Committee on Children, Youth, and Families, House of Representatives, 101st Cong., 2d Sess. (1990) 16

Grimm, *Drug Exposed Infants Pose New Problems for Juvenile Courts*, 11 Youth Law News 9 (1990) 20

Kandall, *Treatment Options For Drug Exposed Infants*, 149 Nat'l Institute on Drug Abuse 78 (1995) 19

Kronstadt, *Complex Developmental Issues of Prenatal Drug Exposure*, 1 The Future of Children 36 (1991) 20

Lockwood, *What's Known and What's Not Known About Drug Exposed Infants*, 11 Youth Law News 15 (1990) 13, 17

TABLE OF AUTHORITIES – Continued

Page

MacGregor, Keith, Bachicha & Chasnoff, *Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome*, 74 Obstetrics and Gynecology 882 (1989) 17

United States General Accounting Office, *Drug Exposed Infants, A Generation at Risk: Report to the Chairman, Committee on Finance, U.S. Senate* 9 (1990 GAO/HRD – 90-138) 17

Weston, Ivins, Zuckerman, Jones, Lopez, *Drug Exposed Babies: Research and Clinical Issues*, 9 Zero to Three: Bulletin of the National Center for Clinical Infant Programs 1 (1989)..... 15

Woods, *Clinical Management of Drug Dependency in Pregnancy*, 149 Nat'l Institute on Drug Abuse 39 (1995) 16, 20

Zuckerman & Bresnahan, *Developmental and Behavioral Consequences of Prenatal Drug and Alcohol Exposure* 38 (6) The Pediatric Clinics of No. Am. J. 1387 (1991)..... 15, 17, 19, 20

Zuckerman, et al., *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, 320 New Eng. J. Med. 762 (1989) 17

Zuckerman, Frank & Brown, *Overview of the Effects of Abuse and Drugs on Pregnancy and Offspring*, 149 Nat'l Institute on Drug Abuse 16 (1995) 15, 16, 19, 20

STATEMENT OF INTEREST

Amicus Curiae the American Medical Association (the "AMA")[1], an Illinois non-profit corporation, represents approximately 300,000 physicians who practice throughout the United States, including South Carolina. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.

The holding of the United States Court of Appeals in *Ferguson v. City of Charleston*, 186 F.3d 469 (4th Cir. 1999), raises issues of significant interest to the AMA, because they concern the public health. The drug-testing practices at issue in this appeal are at odds with AMA research and policies concerning drug abuse. In the view of the AMA, those practices are not an effective means of addressing the problem of illegal drug usage. Moreover, the criminal penalties incorporated in the policy, and the burden imposed on physicians to enforce the policy, places physicians in a potentially adversarial relationship with their patients. Consequently, the policy undermines the absolute trust needed to sustain a successful physician/patient relationship. By eroding patients' faith in the confidentiality of their medical care, the drug-testing plan discourages pregnant mothers from seeking adequate

---

[1] Counsel for the AMA authored this brief in its entirety. No monetary contributions to the preparation or submission of this brief were received from any source other than the AMA. Sup. Ct. R. 37.6.

care for their unborn children. Undermining the physician/patient relationship eliminates a window of opportunity for the physician to encourage sufficient postnatal care, as well.

The AMA believes that the Fourth Circuit's decision was in error, but the AMA does not file this brief in support of either party to the appeal. The AMA's interest lies solely in elucidating the medical background which underlies the legal questions that this Court must address.

SUMMARY OF ARGUMENT

The Fourth Circuit upheld a practice at the Medical University of South Carolina (MUSC), finding that the policy effectively furthered the public health. According to local law enforcement authorities, the policy was implemented to protect infants from *in utero* exposure to cocaine. In the view of the AMA, however, the protective instincts that purportedly motivated the authorities were, in fact, undermined by the policy. The drug-testing and law enforcement reporting policy, hereinafter, the "Charleston policy" or "the policy", is contrary to objective scientific research and to the consensus judgment of American medicine.

The Charleston policy reflects a basic misunderstanding of the nature of drug abuse. In the experience of medical science, drug abuse is a disease that requires treatment and education. It cannot be cured merely by an exercise of self-discipline, nor can it be cured by subjecting addicts to criminal penalties. By implementing the

policy, Charleston authorities necessarily implied that, when faced with the threat of criminal prosecution, a pregnant woman can simply decide to stop abusing drugs. The concept is unlikely to succeed and, consequently, will deprive pregnant women and their children, before and after birth, of effective medical treatment.

Attaching a threat of arrest to a drug-testing policy also weakens the physician/patient relationship. This relationship, which is central to the practice of medicine, depends upon confidential, frank discussions between patient and physician. Knowing that discovery of drug use may lead to arrest, a patient will avoid treatment altogether, or, at a minimum, will be reluctant to disclose such drug use. As a result, the potential harm to unborn infants was increased, not decreased, by the Charleston policy. The benefits of regular medical treatment during the course of pregnancy are obviously lost if a woman ceases contact with medical professionals; similarly, treatment is compromised if the patient has an incentive to refrain from disclosing drug abuse. The resulting lack of appropriate medical care deprives the patient and her fetus of treatment for the high-risk medical conditions that frequently accompany drug abuse, in addition to deprivation of treatment for the drug abuse itself. The lost opportunities for medical intervention at this important stage of fetal development may also result in poor postnatal care and development.

Moreover, the drug-testing policy forces physicians to compromise their commitment to patient confidentiality, as codified in AMA guidelines. By requiring physicians to act as agents of law enforcement, the Charleston

policy undercuts the physicians' ethical obligation to act as patient advocates and protectors.

ARGUMENT

In ruling that the Charleston policy did not violate the Petitioners' Fourth Amendment rights, the Fourth Circuit relied on the "special needs" exception to the Fourth Amendment. *Ferguson v. City of Charleston*, 186 F.3d 469, 476 (1999). This exception arises when "special needs" – other than crime detection – are alleged in justification of a Fourth Amendment intrusion. It involves a context-based analysis (*Chandler v. Miller*, 520 U.S. 305 (1997)), in which the court is to weigh "the individual's privacy expectations against the Government's interests to determine whether it is impractical to require a warrant or some level of individualized suspicion in the particular context." *Ferguson*, 186 F.3d at 476, citing *National Treasury Employees Union v. Von Raab*, 489 U.S. 656 (1989). "The balancing requires consideration of the governmental interest prompting the invasion; the effectiveness of the intrusion, i.e., the degree to which the intrusion reasonably is thought to advance the governmental interest; and the magnitude of the intrusion upon the individuals affected, from both a subjective and objective standpoint." *Ferguson*, 186 F.3d at 476.

This brief addresses the appellate court's application of the "effectiveness" prong of the special needs test and also provides an objective evaluation of the intrusion on

individual autonomy. The *Ferguson* court held that urinalysis is the "only effective means available to accomplish the primary policy goal of persuading women to stop using cocaine during their pregnancies in order to reduce health effects on children exposed to cocaine *in utero*." *Id.* at 478. The AMA respectfully suggests that the Fourth Circuit neglected to identify the true policy at issue in this case. Regardless of its effectiveness in identifying the ingestion of cocaine (*Id.*), the urinalysis was not, alone, the policy implemented at MUSC. The policy must be viewed in its entirety, i.e., a urine test that placed pregnant women at risk of arrest if their urine tested positive for cocaine. The incorporation of possible criminal penalties into the urine-testing regimen transformed a medical procedure into a tool of law enforcement. The failure to correctly identify the true policy crafted by Charleston authorities necessarily places the assumptions of the Fourth Circuit regarding "effectiveness" in doubt. Indeed, by relying on the threat of criminal sanctions as the ultimate means to enforce the drug-testing policy, the law enforcement authorities adopted a distinctly ineffective means of furthering the health of children *in utero*, as well as their mothers.

The Charleston policy was ineffective on several different levels. The policy reflected a fundamental misunderstanding of the nature of drug abuse and addiction. Moreover, the policy eroded the trust and openness central to the physician/patient relationship and effective patient care. By undermining the physician/patient relationship, the drug-testing regimen reduced the likelihood that the patients' children would receive needed medical care, *in utero* and after their birth.

I. Criminal Sanctions Are Not Effective in Halting Drug Abuse by Pregnant Women.

The Charleston policy subjected women who refused treatment, or failed to complete treatment to the satisfaction of law enforcement, to arrest. *Id.* at 474. Implicit in this policy is the assumption that the threat of criminal prosecution is sufficient to cause a woman to stop abusing drugs. In other words, patients who truly want to avoid prosecution will do so through will power and forced treatment. This assumption is flawed. Drug abuse signifies an addiction, particularly where the drug at issue is cocaine. Addiction is a disease, not a reflection of poor discipline. The hallmark of addiction is an inability to cease drug use, despite the possibility of adverse consequences. Thus, by resorting to arrest as the ultimate enforcement of its policy, Charleston authorities failed to acknowledge an elemental tenet of medical science and endorsed a response to drug abuse that the medical community has found to be fundamentally flawed.

The medical profession has long recognized that drug dependence is an illness that cannot generally be overcome without consensual treatment. "Psychoactive Substance Dependence" is listed as a mental illness with specific diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R), which is prepared by the American Psychiatric Association and used by physicians to diagnose mental illness. The DSM-IV-R describes substance dependence as

> [a] cluster of cognitive, behavioral, and physiologic symptoms indicating that the individual

> continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior. The symptoms of dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal. American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R)* 176 (4th ed. rev. 1994).

The AMA has itself examined the problem of drug dependence and issued a comprehensive analysis. According to the report,

> Treatment – in the form of medical, psychological and psychiatric care – is a necessary and appropriate response to drug abuse. Reluctance to provide such care to drug abusers reflects unwarranted misconceptions about the nature of addiction. While there is much to be learned about drug dependency, it is clear that addiction is not simply the product of a failure of individual willpower. Instead, dependency is the product of complex hereditary and environmental factors. It is properly viewed as a disease, and one that physicians can help many individuals control and overcome. American Medical Ass'n, *Proceedings of the House of Delegates: 137th Annual Meeting*, Board of Trustees Report NN 236, 241 (June 26-30, 1988) ("AMA Rpt. NN").

In addition to social and psychological causes, drug dependence, like other diseases, is significantly influenced by biologic or genetic factors. *Id.* at 247.

Case law also recognizes that drug addiction is an illness requiring medical treatment. As early as 1925, this

Court stated that addicted persons are "diseased and proper subjects for [medical] treatment." *Linder v. United States*, 268 U.S. 5, 18 (1925). The Court reaffirmed this principle in *Robinson v. California*, 370 U.S. 660 (1962), when it found unconstitutional a law making the status of narcotic addiction a criminal offense. The Court stated that "narcotic addiction is an illness which may be contracted innocently or involuntarily." *Id.* at 667. In his concurring opinion in *Robinson*, Justice Douglas noted that,"the addict is under compulsions not capable of management without outside help." *Id.* at 671.

Because addicted individuals are physically and psychologically dependent on the substance to which they are addicted, they are unable to stop using the drug without outside assistance. People addicted to illicit substances have impaired ability to decide whether to continue their use of those substances. American Medical Ass'n, *Legal Interventions During Pregnancy*, 264 J.A.M.A. 2663, 2667 (1990) (*"Legal Interventions"*). In fact, as described by DSM-IV-R, one of the fundamental characteristics of drug dependency is the inability to reduce or control substance abuse despite adverse consequences. DSM-IV-R, at 178-79; see also American Medical Ass'n, *Policy Compendium* H-95.976 at 229 (1999) (Appendix) (stating that "alcoholism and drug dependence . . . are diseases characterized by compulsive use in the face of adverse consequences.")

More importantly, because of the compulsive nature of drug dependency, criminal sanctions are unlikely to achieve the goal of deterring drug use among pregnant women. As the Board of Trustees of the AMA has pointed out, punishing people for substance abuse:

> ignores the impaired capacity of substance-abusing individuals to make decisions for themselves. In all but a few cases, taking a harmful substance such as cocaine is not meant to harm the fetus but to satisfy an acute psychological and physical need for that particular substance. If a pregnant woman suffers from a substance dependency, it is the physical impossibility of avoiding an impact on fetal health that causes severe damage to the fetus, not an intentional or malicious wish to cause harm. *Legal Interventions*, at 2667-68.

For these reasons, the AMA promotes education and treatment for drug abusers, not criminalization. Specifically, the AMA "oppose[s] legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement – gathering evidence for prosecution rather than provision of treatment." American Medical Ass'n, *Policy Compendium* H-420.970 at 612 (1999) (Appendix) ("AMA Policy H-420.970"). The AMA supports the funding of "maternal drug addiction treatment rather than prosecution." *Id.* Recognizing the inefficacy of criminalizing drug abuse as a means of preventing fetal exposure to drugs, the AMA has also expressly found that "[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate." American Medical Ass'n, *Policy Compendium* H-420.969 at 612 (1999) (Appendix). Similarly, the AMA believes that drug abuse is not a "criminal activity" but should be treated like the disease that it is. AMA Policy H-420.970 (Appendix); see also American Medical Ass'n, *Policy Compendium* H-420.962 at 610 (the AMA encourages the federal government to increase funds directed to "drug treatment,

prevention and education" and reaffirms that pregnant substance abusers should be provided with rehabilitative treatment tailored to their individual needs); H-95.983 at 231 (1999) (the AMA "encourages . . . government and other policymakers to become more well informed about drug dependencies, and to base their policies and activities on the recognition that drug dependencies are, in fact, diseases.") (Appendix).

Criminal penalties for possession of illicit substances already exist. However, these sanctions have generally been ineffective. Pregnant women who are not deterred by existing penalties are unlikely to be affected by additional sanctions. Therefore, the Charleston policy fails to effectively advance the alleged governmental interest in shielding fetuses from *in utero* cocaine exposure.

II. The Charleston Policy Discouraged Prenatal and Postnatal Care by Undermining the Physician/Patient Relationship.

The Charleston policy failed the special needs balancing test (*Ferguson*, 186 F.3d at 476) in other ways, as well. The Charleston policy could not have been implemented unless pregnant women submitted themselves to medical treatment. Yet pregnant women will inevitably avoid medical care if their physicians are compelled to report positive urine test results to law enforcement. A policy that results in substance abusing expectant mothers avoiding medical treatment obviously cannot be effective in enhancing the medical welfare of their fetuses. By turning the doctor/patient relationship into a potentially

hostile encounter, any possible effectiveness of the drug-testing plan is lost.

Meaningful medical care depends on a successful physician/patient relationship. At the core of this relationship lies trust and openness between the patient and the physician. People seek medical care with the understanding that confidences disclosed to their physician will not be revealed to third parties. Without complete faith in the sanctity of discussions with their physicians, patients will be reluctant to disclose potentially incriminating behaviors, even if such disclosures are necessary to receive diagnosis or treatment. American Medical Ass'n, *Policy Compendium* E-5.05 at 98 (1999) ("The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services.") (Appendix).

Drug-testing regimens like the Charleston policy drive a wedge between physicians and pregnant patients[2]. Once they know that urinalysis may lead to

---

[2] The AMA recognizes that, on occasion, physicians must report criminal conduct by patients, or imminent harm threatened by or to their patients. See, e.g., American Medical Ass'n, *Policy Compendium* E-5.05 at 98; H-515.969 at 696 (recognizing existence of mandatory disclosure requirements for domestic violence); H-515.982 at 699-70 (physicians must familiarize themselves with "state reporting requirements" for "family violence"); H-515.992 at 701 (AMA supports legislation mandating reporting of elderly abuse); H-515.999 at 702 (AMA urges state medical societies to advise physicians of their responsibilities under child abuse laws) (1999). The harm inherent in the Charleston policy is the failure to recognize that, unlike other reportable conduct, the behavior at issue here is not avoidable, since the behavior itself is a disease. As stated

arrest, pregnant women will be motivated to conceal any drug use, or, more likely, will avoid medical treatment completely. American Medical Ass'n, *Perinatal Addiction: Issues in Care and Prevention*, Report of the Council on Scientific Affairs, Rpt. G. at 5 (1992) (*"Perinatal Addiction: Issues in Care and Prevention"*) (women who fear prosecution avoid prenatal care). By eroding the foundations of the physician/patient relationship, such plans prompt pregnant women, and particularly those ingesting cocaine, to avoid any prenatal care. An absence of prenatal care has lasting, far-reaching ramifications. Women who avoid treatment for drug abuse during pregnancy expose their unborn children to *in utero* damage from other, dangerous behaviors that frequently accompany drug use. They are also less likely to engage in adequate postnatal care, or to seek treatment to end their drug abuse. Thus, the negative consequences of a surreptitious drug-testing campaign like the one implemented in this case can extend well beyond a mere failure of the policy's stated purpose of intervening medically on behalf of infants exposed *in utero* to cocaine.

A. Failure to Disclose Drug Use Can Delay Treatment for Harm Caused by Exposure.

Drug use is one of the most commonly missed diagnoses in obstetric and pediatric medicine. Chasnoff, *Drug Use in Pregnancy: Parameters of Risk*, 35 The Pediatric Clinics of No. Am. J., 1403, 1410 (1988) ("Chasnoff"). In

---

previously, the AMA contends that the disease is best addressed by education and treatment, not criminal penalties.

most cases, a patient's drug use is not apparent if the patient does not disclose it. Drug tests alone cannot be relied upon to diagnose drug use. American Medical Ass'n, *The Reduction of Medical and Public Health Consequences of Drug Abuse*, Report of the Council on Scientific Affairs, Rpt. 8-A-97 at 3 (1997). It has been estimated, for example, that postnatal toxicology screens may miss up to 50% of infants exposed prenatally to drugs. Lockwood, *What's Known and What's Not Known About Drug Exposed Infants*, 11 Youth Law News 15, 15 (1990) ("Lockwood"), citing Halfon, "Born Hooked," testimony before the U.S. Select Committee on Children, Youth, and Families (April 1989). Cocaine use is particularly difficult to diagnose through testing. Cocaine metabolites can be detected through urinalysis for only 24 to 72 hours after ingestion of cocaine. This creates problems for diagnosis because, unlike opiates or alcohol, cocaine is not generally used on a daily basis. Instead, use is characterized by episodic, prolonged high-intensity binges that are interspersed with days of abstinence or low-intensity use. Gain & Clabber, *Abstinence Symptomology and Psychiatric Diagnosis in Cocaine Abusers: Clinical Observations*, 43 Arch. Gen. Psychiatry 107, 107 (1986). Thus, even the most chronic user will at times have no cocaine metabolites in her urine.

This evidence demonstrates that, because of the limitations of drug screening, voluntary disclosure of drug use is the most effective means of treating the cocaine-exposed unborn child. Voluntary disclosures will not occur in the absence of an open, trusting physician/patient collaboration. The necessary trust will not exist

when one party to the collaboration must report the drug use of the other party to law enforcement authorities.

By contrast, when physicians and patients work together, with a shared goal of achieving the best possible outcome for mother and child, outcomes are improved. With appropriate prenatal counseling, women will reduce the impact of their addiction on their fetuses. *Perinatal Addiction: Issues in Care and Prevention*, at 7. One Philadelphia program, which treated pregnant heroin users with methadone maintenance, found that because of women's concerns about the impact of methadone on their unborn fetuses, the women were able to reduce their methadone to relatively low doses. Finnegan, Connaughton, Emich & Wieland, *Comprehensive Care of the Pregnant Addict and Its Effect on Maternal and Infant Outcome*, 1 Contemp. Drug Problems 795, 797 (1972) ("Finnegan"). A drug-testing policy truly committed to reducing harm to children *in utero* would, therefore, encourage frank and full communication between patient and physician. Frustrating incentives for voluntary disclosures by patients will have the opposite effect.

B. Even If Drug Use Is Not Discontinued, Prenatal Care Can Significantly Reduce The Risk of Harm to Infants.

The negative health effects associated with prenatal drug exposure can be significantly reduced through adequate prenatal care and counseling, even if women do not discontinue their drug use. Many of the adverse outcomes seen in drug-exposed infants may be caused by socioeconomic and lifestyle factors associated with drug

use rather than by drug use itself. Zuckerman, Frank & Brown, *Overview of the Effect of Abuse and Drugs on Pregnancy and Offspring*, 149 Nat'l Institute on Drug Abuse 16, 19 (1995) ("Zuckerman, Frank & Brown"); *Perinatal Addiction: Issues in Care and Prevention*, at 3; Zuckerman & Bresnahan, *Developmental and Behavioral Consequences of Prenatal Drug and Alcohol Exposure*, 38(6) The Pediatric Clinics of No. Am. J. 1387 (1991) ("Zuckerman & Bresnahan"); Chasnoff, at 1408-1410; Cherukuri, Minkoff, Feldman, Parekh, & Glass, *A Cohort Study of Alkaloidal Cocaine ("Crack") in Pregnancy*, 72 Obstetrics and Gynecology 147, 150 (1988). Several risk factors are associated with drug use. First, the use of illicit substances is highly correlated with the use of licit but nevertheless harmful substances such as alcohol and cigarettes. See, e.g., Frank, Zuckerman, et al., *Cocaine Use During Pregnancy, Prevalence and Correlates*, 82 Pediatrics 888, 892 (1988) ("Frank"); Chasnoff, at 1408, 1410; Weston, Ivins, Zuckerman, Jones, Lopez, *Drug Exposed Babies: Research and Clinical Issues*, 9 Zero to Three: Bulletin of the National Center for Clinical Infant Programs 1, 4 (1989) ("Weston"); AMA Rpt. NN, at 236, 248. These licit substances are particularly dangerous to fetal health. Fetal alcohol syndrome is now the leading known cause of mental retardation in the Western World, exceeding both Down syndrome and cerebral palsy. American Medical Ass'n, *Proceedings of the House of Delegates: 43rd Interim Meeting*, Board of Trustees Report Y 95, 105 (Dec. 3-6, 1989) ("AMA Rpt. Y"). Overall, fetal alcohol syndrome is one of the three leading causes of birth defects and the only one which is currently preventable. AMA Rpt. NN, at 248. Similarly, cigarette smoking increases the likelihood of spontaneous

abortion, premature birth, perinatal mortality, and low birth weight, and negatively affects later growth and development. *Legal Interventions*, at 2666; see also *Getting Straight, Overcoming Treatment Barriers for Addicted Women and Their Children: Hearing Before the Select Committee on Children, Youth, and Families, House of Representatives*, 101st Cong., 2d Sess. (1990) (Fact Sheet at 7) ("Fact Sheet, *Hearing*.")

Another problem commonly associated with drug use and potentially harmful to infant health is poor nutrition. Zuckerman, Frank & Brown, at 19. Studies have shown that drug-using women have lower pregnancy weights and less weight gain during pregnancy than non-users. Frank, at 892. Drug users are also more likely to suffer from anemia. *Id.*; AMA Rpt. Y, at 97.

Similarly, drug-using women are also at risk of exposure to sexually transmitted diseases, including AIDS. Woods, *Clinical Management of Drug Dependency in Pregnancy*, 149 Nat'l Institute on Drug Abuse 39, 47 (1995) ("*Clinical Management of Drug Dependency*"); Zuckerman, Frank & Brown, at 19; AMA Rpt. Y, at 101; see also, Fact Sheet, *Hearing*, at 5, citing The National Institute on Drug Abuse, 1990. Cocaine, particularly, can be injected intravenously, which greatly increases the chance of becoming infected with HIV through the use of a contaminated needle. AMA Rpt. NN, at 247. When women contract sexually transmitted diseases or HIV infection, their fetuses are also at risk. Fact Sheet, *Hearing*, at 7, citing the Centers for Disease Control, 1990. Other risk factors associated with drug use include co-existing maternal mental

illness, non-sexually transmitted infections such as hepatitis, and the possibility of inadvertent maternal overdose. AMA Report Y, at 97; Lockwood, at 16.

Through prenatal care and counseling, women can come to understand the risk factors associated with drug use and be encouraged to reduce or avoid them. This would greatly reduce the risk of harm to infants. For example, low birth weight, a primary cause of infant mortality and disability as well as higher health care costs, is commonly associated with prenatal drug exposure. *Perinatal Addiction: Issues in Care and Prevention*, at 1. One study found that, while cocaine-exposed infants were on average 400 grams lighter at birth than non-exposed infants, only 25% of this difference was attributable to cocaine use itself. Among the factors responsible for the other 75% of the deficit were poor maternal nutrition and cigarette smoking. Zuckerman, et al., *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, 320 New Eng. J. Med. 762, 767 (1989); see also Zuckerman & Bresnahan, at 10. In accordance with this finding, adequate prenatal care has been shown to reduce the incidence of low birth weight among drug-exposed infants by 18 to 50 percent (United States General Accounting Office, *Drug Exposed Infants, A Generation at Risk: Report to the Chairman, Committee on Finance*, U.S. Senate 9 (1990 GAO/HRD-90-138)) and to significantly reduce the incidence of perinatal morbidity among cocaine-exposed infants. MacGregor, Keith, Bachicha & Chasnoff, *Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome*, 74 Obstetrics and Gynecology 882, 884 (1989).

Open communication with physicians regarding drug use is also necessary to insure safe deliveries. Narcotic analgesia and morphine are commonly administered to patients during labor and delivery. Women who abuse narcotics such as heroin or methadone are, therefore, at risk of overdose during labor and delivery if physicians are unaware of their drug use. If physicians are aware of maternal drug use, they can avoid these types of medication or carefully monitor their use during labor and delivery to prevent overdose. Finnegan, at 798.

Detection of high risk behaviors requires contact and uninhibited communication with medical providers. Prenatal care must be offered in an environment of cooperation and trust. Physicians cannot detect potential problems and provide counseling if women are unwilling to be completely frank about their lifestyles. With appropriate counseling and assistance, many women would be able to avoid additional risks to their infants even if they are unable to stop using drugs. Neither logic nor experience suggests that such counseling and assistance is feasible in an atmosphere of mistrust and coercion.

C. Positive Contact With Medical Providers Prenatally Can Contribute to Postnatal Infant Health and Development. Criminalization Detracts From Postnatal Development.

Just as a variety of prenatal factors affect neonatal outcomes, numerous postnatal factors affect the long-term developmental outcomes of drug-exposed infants. Drug exposure and other prenatal risk factors create a "biologic vulnerability" which can be compensated "by

competent caretaking, but which renders the child more vulnerable to the effects of poor caretaking." Zuckerman & Bresnahan, at 1-2; see also Zuckerman, Frank & Brown, at 18. For example, cocaine-exposed infants "tend towards hyperactivity and decreased social responsiveness." Kandall, *Treatment Options For Drug Exposed Infants*, 149 Nat'l Institute on Drug Abuse 78, 94 (1995) ("Kandall"); *Perinatal Addiction: Issues in Care and Prevention*, at 4. For optimal development of such children, their caretakers must be informed of the most effective interactive techniques to use with the children: "gentle handling with support of the head and body, soft social talking, and eye contact without overstimulation." Kandall, at 94. Prematurity, which is commonly associated with prenatal exposure to various substances, may cause neurologic immaturity and therefore lead to low IQ scores. In one study, however, only those neurologically immature infants who had poor caretaking during their first two years had subnormal IQ scores. Neurologically immature infants with caretakers attuned to their particular needs developed normal IQ scores. Zuckerman & Bresnahan, at 4. Positive, regular contacts with physicians during pregnancy, therefore, may influence whether children receive adequate postnatal care.

Consistent interaction with healthcare providers also increases the possibility that women will seek treatment for their drug abuse. This, too, yields benefits to the infant prenatally as well as postnatally. Even if drug treatment cannot be accomplished during pregnancy, the development of a positive alliance with health care providers makes it more likely that women can be brought into treatment later. Treatment experts concur that the

motivation created by pregnancy offers a unique opportunity for positive intervention into the lives of drug-dependent women. *Clinical Management of Drug Dependency in Pregnancy*, at 42-43. Maternal drug treatment, at whatever point possible, is necessary to the healthy development of a child because drug-dependent women may be unable to provide a supportive environment for their children's development unless they are able to overcome their addiction. Zuckerman & Bresnahan, at 34; Krondstadt, *Complex Developmental Issues of Prenatal Drug Exposure*, 1 The Future of Children 36, 45 (1991) ("Krondstadt"). In addition, many drug-dependent women lack proper models for parenting and can be helped in their role as parents by positive intervention from the health care or social service community. Chasnoff, at 1409-1410. Even where successful intervention strategies for vulnerable children and their families exist, these cannot be implemented in an environment that drives women away from health and social service providers. Krondstadt, at 45.

Bringing women into drug treatment, whenever possible, is critical for a woman's other children as well. *Perinatal Addiction: Issues in Care and Prevention*, at 3; Zuckerman, Frank & Brown, at 19. In a 1986 survey, members of the National Council of Juvenile and Family Court Judges estimated that substance abuse among adults was a significant factor in 60-90% of the cases referred to their courts. Grimm, *Drug Exposed Infants Pose New Problems for Juvenile Courts*, 11 Youth Law News 9, 9 (1990). The unique opportunity for positive intervention during pregnancy should not be lost.

On the other hand, if mothers of drug-exposed infants are convicted and imprisoned, they will be unable to care for their infants or other children, and foster placement will be unavoidable. Lengthy temporary placements in foster care are extremely detrimental, especially for infants. Children in foster care are deprived of the opportunity to begin bonding with their mothers. In addition, child welfare agencies are not equipped to provide substitute care. In many areas, there are not enough foster parents even for healthy children and fewer still who are trained to provide the kind of specialized care required by some drug-exposed infants. This means that children may either be placed in unqualified homes which might cause permanent harm, or be left as "boarder babies" in hospitals and other inappropriate long term shelters. *Id.* at 12; *Perinatal Addiction: Issues in Care and Prevention,* at 5.

The discontinuity brought about by temporary foster placement can be devastating for children's psychological development. Children reared without permanent parental relationships may have higher levels of language retardation and diminished mental development, as well as higher rates of delinquency. Several serious personality disorders also correlate with multiple separations from parental figures. Garrison, *Why Terminate Parental Rights?,* 35 Stan. L. Rev. 423, 458 (1983). In the absence of regular, positive contacts between health care professionals and pregnant mothers, therefore, the potentially devastating effects of poor prenatal care can extend far beyond the birth of the at-risk child.

CONCLUSION

The AMA urges reversal of the Fourth Circuit's decision, for reconsideration. The AMA believes that the Fourth Circuit was mistaken in its understanding of drug abuse. Drug abuse is a disease amenable to medical treatment. It is not a criminal activity, and criminal sanctions are an inappropriate means of addressing this public health problem.

Respectfully submitted,

MICHAEL ILE*
ANNE MURPHY
LEONARD NELSON
CAROLYN QUINN
AMERICAN MEDICAL ASSOCIATION
515 N. State St.
Chicago, IL 60610
312/464-5000

Attorneys for Amicus Curiae
(**Counsel of Record*)

APPENDIX

AMA Policies E-5.05, H-95.976, H-95.983, H-420.962; H-420.969; H-420.970

E-5.05 **Confidentiality**. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also, communicable diseases, gun shot and knife wounds should be reported as required by applicable statutes or ordinances. Issued December 1983; Updated June 1994.

H-95.976 **Drug Abuse in the United States – the Next Generation:** The AMA is committed to

efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;

(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;

(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;

(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;

(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism,

and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;

(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;

(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and

(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89)

H-95.983 **Drug Dependencies as Diseases**: The AMA (1) endorses the proposition that drug dependencies, including alcoholism, are diseases and their treatment is a legitimate part of medical practice, and (2) encourages physicians, other health professionals, medical and other health related organizations, and government and other policymakers to become more well informed about drug dependencies, and to base their policies and activities on the recognition that drug dependencies are, in fact, diseases. (Res. 113, A-87; Reaffirmed by CSA Rep. 14, A097; Reaffirmed: Sunset Report, I-97 Reaffirmed: CME Rep. 10, I-98)

H-420.962 Perinatal Addiction – Issues in Care and Prevention: The AMA: (1) adopts the following statement: transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education within the context of its "War on Drugs." In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, and encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs; (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol abuse during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care; and (6) will address the special needs of pregnant drug abusers within the course of providing prenatal care; and (6) will address the special needs of pregnant drug abusers within the

context of its ongoing Health Access America programs. (CSA Rep. G, A-92)

H-420.969 Legal Interventions During Pregnancy: Court Ordered Medical Treatments and Legal Penalties For Potentially Harmful Behavior By Pregnant Women: (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs. (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of

failure to comply with the physician's recommendation. (BOT Rep. OO, A-90)

H-420.970 **Treatment Versus Criminalization – Physician Role in Drug Addiction During Pregnancy:** It is the policy of the AMA (1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity; (2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services; (3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement – gathering evidence for prosecution rather than provision of treatment; and (4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same. (Res. 131, A-90)